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The active ingredients of intentional recovery communities: Focus group evaluation

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Abstract

Background: Recovery amongst people with a severe mental illness is generally defined as a multi-dimensional process of transformation involving positive transitions across various psychosocial domains. Recent work on recovery has focused on addressing deficits in social relationships, social skills and social support. In an attempt to foster recovery and psycho-social rehabilitation amongst people with severe mental illness, four intentional recovery communities have been set up by a mental health services provider in Washington DC, guided by the principles underlying therapeutic communities developed elsewhere.

Aims: We set out to explore and elucidate whether components of these communities appeared to assist recovery from the point of view of consumers, and if so which were the most important factors.

Methods: Four focus groups were conducted, one for each community. We analysed data using grounded theory techniques.

Results: Three themes strongly emerged as important factors within the communities influencing recovery. These were the community as a place of safety, the community as surrogate family, and the community as socialization.

Conclusion: These three factors appear to be important components of intentional recovery communities.

Declaration of interest: None.

Keywords: *Recovery, qualitative, mental health services, social support, severe mental illness*

Introduction

The New Freedom Commission on Mental Health (2003) prioritizes the importance of recovery for people diagnosed with severe mental illness (SMI) in the United States. Recovery is generally defined as a multi-dimensional process of transformation, involving positive transitions in various domains, including work, social functioning, community participation and education (Anthony, 1993; Deegan, 1996, 1997). Measures of success on the road to recovery include employment, independent living and formation of mutually supportive inter-personal relationships (Deegan, 1988). Mancini et al. (2005) call this ''a process of regaining one's life and the mindset that develops as a result''.

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Much work on recovery has focused on deficits in social relationships, social skills and social support. Boydell et al. (2002) note that people with SMI often lack the ability to create or maintain a community. As a consequence, they may lose out on all the positive benefits that research has shown to be concomitant with a strong and solid social network (Kawachi & Berkman, 2001; Cohen & Wills, 1985; Brugha, 1995). In fact, loneliness, isolation and difficulty forging meaningful relationships appear to be serious and common problems for people living with a SMI (Beal et al., 2005; Borge et al., 1999; Estroff, 1983). Consistent with the rehabilitative approach to psychiatry, addressing these ''problems in living'' through non-pharmaceutical measures has long been a pre-occupation of progressively minded mental health professionals (Allen & Haslam-Hopwood, 2005). In fact, strong evidence is accumulating that psychosocial interventions can play a significant role in assisting incremental recovery; a goal now shared by government, clinicians and consumers alike (Davidson, 2005; Deegan, 1988; Surgeon-General, 1999).

One method of facilitating this form of psychiatric rehabilitation has been the intentional formation of therapeutic communities for people struggling with a SMI (Munich & Lang, 1993; Hinshelwood & Manning, 1979). These communities generally aim to address residents' social and cognitive deficits through a mixture of ongoing formal and informal interaction with staff and peers. Well known examples include Fairweather Lodges (Fairweather et al., 1969), Chestnut Lodge (Silver, 1997), Kingsley Hall (Barnes & Berke, 1973) and Fountain House (Fountain House, 1999). Other forms of organized community, such as self-help groups, have also been shown to facilitate recovery in people with SMI (Wallerstein, 1986).

Following this tradition and in line with the recovery paradigm, Community Connections, a mental health services provider in Washington DC, has recently set-up four ''intentional recovery communities'' (see Table I for outline and description). The four communities are: an empowerment center for abused women with a SMI, a residential community for men and women with co-occurring SMI and substance abuse, an after-school program for troubled inner-city teens and a traditional psycho-social day program for people with a SMI. The communities intend to address the psycho-social needs of people with multiple vulnerabilities in addition to mental illness: pervasive substance abuse problems, histories of trauma, exposure to violence, homelessness, and involvement with the criminal justice system. Unlike most previous ''therapeutic communities'', each of the four recovery communities was specifically tailored to assist the process of recovery in a particular SMI sub-population (i.e., abused women, dual diagnosis population, troubled teens). The recovery philosophy propelled the formation and development of the recovery communities. One primary aim of the recovery community was to help address the social deficits identified

Table I. Description of the four Intentional Recovery Communities.

Recovery community	Number of members	Core description
Women's Empowerment Center	15–25	Open Monday–Friday 10am–4pm for women only, with activities, staff support and peer support specialists
Residential Community	13	Supported apartments in a converted building, with tenant council and other social activities.
Day Program	20	Open Monday–Friday 8.30am–3pm with structured social and learning activities
Adolescent Group	8–12	Open twice weekly after school and during school holidays with structured and unstructured activities.

in the extant literature as an important factor in the everyday lives of people with SMI. It was hoped that the communities would become safe and nurturing environments where people could give and receive instrumental and psychosocial support; where people could learn, listen, speak, trust and grow by regular contact with peers and staff (Harris & Fallot, 2005). By drawing on a unique, consumer-driven blend of peer support and professional staff services, it was hoped that shared responsibility would be fostered and mutual help provided; factors previously identified as assisting recovery (Daloz, Keen, Keen, & Parks 1996; Harris, Fallot, & Berley, 2005). Unlike the previously studied ''therapeutic communities'' mentioned earlier in the introduction, our communities were not conceptualized as ''half-way houses'' between an institution and the community. In fact, they were considered an ongoing support to ''being in the world''; a facilitative environment where relationships can be built and ongoing socialization can occur.

All four communities began at the start of 2005. After 6 months of community development, we decided to evaluate their impact on aspects of consumers' recovery. A qualitative approach is often recommended as an appropriate evaluative strategy to learn about the impact of new developments in psychiatry on consumers (Whitley & Crawford, 2005). Considering that the recovery communities represent innovation with regards to conventional mental health services, we chose a qualitative approach to the evaluation. We thought this was also appropriate considering the complex life histories and multiple risk factors of consumers, allowing us to explore everyday aspects of life inside and outside the recovery community. This approach responds to recent calls suggesting that the application of qualitative methods to the recovery paradigm could have significant empirical and theoretical implications in psychiatry (Davidson, 2005; Whitley & McKenzie, 2005). The overall purpose of the evaluation was to discern which aspects of life within the recovery community appear to be facilitating recovery, from the point of view of consumers. In light of the literature regarding social deficits amongst SMI populations, we were particularly interested to discern whether social functioning had improved consequent upon consumers' participation in the recovery community, and if so, what exactly was helping. The evaluation was conducted principally to inform quality improvement at Community Connections. However we herein share our observations as we feel our interpretation has general importance, in that it brings to light key factors identified by consumers participating in the recovery communities that appear to be aiding recovery. Other mental health service providers beyond Community Connections may wish to consider the role of these factors in their own settings.

Methods

Design

Four focus groups were held in total (one for each recovery community), allowing us to make overall observations, as well as comparing and contrasting experience among the four recovery communities. The evaluation was conducted in the summer of 2005. Thirty-eight consumers participated in total, with a breakdown of exact numbers and appropriate demographic information given in Table II. Participants were openly recruited from within the recovery communities by a combination of announcements in consumer meetings and personal invitation. Both methods were used to try and ensure the participation of more involved and more withdrawn members of the community. It was hoped that this design would ensure maximum participation throughout the community. A focus group was held for each recovery community to ensure homogeneity and familiarity amongst participants, recommended by Krueger (1994) as leading to a smooth and fruitful interaction.

Table II. Description of the Focus Groups and their Participants.

Recovery community	Number of participants	Gender	Race
Women's Empowerment Center	12	12 women	11 black, 1 white
Residential Community	7	6 women 1 man	5 black, 2 white
Day Program	10	8 women 2 men	10 black
Adolescent Group	9	6 girls 3 boys	8 black, 1 white
Total	38	32 women, 6 men	34 black, 4 white

Procedures

The focus groups were held at the site of the appropriate recovery community to facilitate participation. They ran for approximately one hour. A well-trained graduate-level facilitator, working with an equally well-trained second observer, moderated each focus group. Women facilitators were chosen to moderate all focus groups in light of the knowledge that women made up the vast majority of community members. For similar reasons, we ensured at least one of the facilitator/second observer dyad was African-American. It has been suggested that this form of matching is a good technique in improving openness, empathy and empowerment in the focus group interaction (Madriz, 2000). The facilitator followed a pre-determined topic guide designed by the authors to explore the experience and impact of involvement in a recovery community. Questions were generally open-ended, allowing participants to prioritize issues they thought were most relevant. Examples of questions include ''what do you think of this community?'', ''what kind of impact has this had on your life?'', and ''what has been helping you in this community?''. Participants were told that they were the experts, rather than the focus group facilitator. This principle was followed throughout the focus group, with the facilitator encouraging open discussion and purposely taking a back seat. Again this was a deliberate policy done to indicate respect for participants' views and experience (Lofland & Lofland, 1995). Focus groups were recorded onto audio-tape and the second observer also took notes during the discussion. Informed consent was obtained and participants were compensated $15 for their time.

Analysis

Data were analyzed according to the grounded theory approach outlined by Glaser and Strauss (1967). This is an inductive method ordaining that analysts do not approach data with a priori categories or hypotheses, but instead develop a posteriori concepts and theory grounded in the experience, language and categories most important to participants. We followed maxims of qualitative analysis in our procedures, involving preliminary identification of commonly occurring themes/concepts. These were then critically developed, amalgamated or abandoned by systematic comparison within and between focus groups (Strauss & Corbin 1990). To add rigor to the study, various parties independently analyzed the data. First, the facilitator and second observer met after each focus group to discuss what was said in the groups. This discussion subsequently formed the basis for a written summary of the focus group. Additionally, the first author independently

listened to the audiocassettes a number of times in order to discern prominent themes. Prominent themes were defined as those that re-occurred throughout the focus group and were mostly consensual amongst focus group participants. The first author then compared his provisional summary with that independently reached by the facilitator and the second observer. Consensus was quite rapidly reached amongst the evaluation team on the principal themes arising from the data. Focus groups were not transcribed, as we believe that familiarity with the data was easily gained through multiple listening and concomitant note taking. This systematic process of distilling and combining data until parsimonious agreement led to the development of the conceptual model presented in the results. Supportive quotations used in the results are emblematic of the wider data set. All have been anonymized to protect consumer confidentiality.

Results

The aim of the evaluation was to uncover whether aspects of recovery communities appeared to be significantly assisting recovery and social functioning, from the point of view of community members, and if so, which ones. Distilled themes could then be used for quality improvement at Community Connections, DC, and may provide a useful model for construction of recovery communities or quality improvement at mental health services elsewhere.

Almost all participants lauded the recovery communities as a significant contributor to positive change in various psychosocial domains. Three aspects of the recovery community appeared to be important in this regard. Though there is significant overlap between these themes, they are differentiated in the results for ease of comprehension. The themes are (i) the community as a place of safety, (ii) the community as a surrogate familiy, and (iii) the community as socialization and individual growth.

A place of safety

The most prominent theme to emerge from the data was that of safety and security. This issue was raised again and again in every focus group, with more frequency and force of comment than any other factor. This seemed particularly important for women and adolescent participants. Consensus was rapidly reached amongst participants that this was an issue of vital important in their recovery. The recovery community was significantly appreciated as a place of physical, psychological and social safety. This was contrasted with life ''on the street'' (and earlier life experience), where violence, danger and exploitation was perceived to be endemic. This was extremely important in the women's recovery community, as many had suffered severe physical and sexual abuse in the past. This feeling of safety allowed participants to connect with others or just ''be themselves'' without fear of danger or exploitation. The feelings of safety and security appeared to be the bedrock upon which positive inter-personal relationships were forged and individual growth occurred. All the participants of this focus group agreed with the following woman's comments, and many echoed it with similar comments of their own:

> We like the fact that the women's empowerment centre is only women, I feel safe and secure, because I love you women and I feel comfortable being in their company, and not having a lot of men, you know, trying to come on to me or anything like that.

Similar views were expressed in other focus groups. The members of the residential community appreciated the fact that they lived in a neighborhood and a building where illicit

drugs or violence are not prevalent. This led to feelings of both physical and psychological safety, assisting those in danger of substance abuse relapse, one woman in the residential community noting:

> We do not have any drug infestation . . . either in here or on the street outside, and that's very good for me, I want to keep clean, I had hit rock bottom, got caught up in the criminal justice system, I have been abused . . . I had a lot of trust issues . . . I wouldn't let people get close to me, but now, I have learnt to trust people.

The theme of safety also emerged in the adolescent focus group. Again security inside the recovery community was contrasted with violence and drugs outside the recovery community. Attendance at the recovery community was preventing exposure to violence and drugs ''on the streets'', as one teenage woman states:

> It's just a place we can come and meet and chill out with our friends and just chill out, we do not have to worry about any type of violence or drugs or anything like that.

There was almost complete unanimity across participants and focus groups regarding the impact of safety within the recovery community. Words and phrases used in the above extracts, such as ''love'', ''trust'', ''safe and secure'', ''comfortable'' and ''chill-out'', were repeated by many other participants. The communities appeared to provide a ''safe space'', where people felt secure and buffered from dangerous exposures prevalent in the external urban environment. These exposures include re-involvement in substance abuse sub-cultures and the development of dysfunctional, exploitative inter-personal relationships. In contrast, being ''inside'' the community appears to facilitate the growth of other interests and the development of meaningful bonds between consumers. The feeling of safety fostered at the recovery communities appeared to be a pre-requisite for positive socialization in this at-risk inner-city population with a history of life-span insult.

Surrogate families

Throughout the four focus groups, participants frequently talked positively about the recovery community as a ''family''. Participants strongly suggested that this was one of the most important aspects of the community, significantly affecting recovery. The role of recovery communities as a surrogate family seemed especially important considering many participants had fractured relations with their own biological family, or simply had no family in the Washington DC area. The recovery communities increased mutual support and empathy with others; one participant's comments in the women's focus group was emblematic of common feeling:

> The women's empowerment centre is like my family, I do not have any family here in DC, I relocated so I come here and look at the girls as my sisters, a place where women like me who have issues, and trauma in my life, I can come and talk about it, I am not alone, I am part of, I am finally a part of something.

In addition to the valuable aspect of peer support alluded to in the previous extract, most consumers considered staff to be equally important members of the surrogate family. All the

focus groups agreed that staff were very supportive, assisting personal growth and development. One of the adolescent participants positively contrasts the staff with his biological family:

> The staff are the best people in the world, they are making up for people, adult people who you have to associate with, they make up for what they lack.

Biological families often provide material, as well as psychosocial support during times of crisis or transition. Consumers lauded recovery communities because, in contrast to conventional mental health services, they also focused somewhat on material support. This was especially so for members of the residential community, who had been provided with a home in which to live. Even the other focus groups mentioned the importance of material support, in the absence of any being provided by close or extended family. Most frequently mentioned was the provision of meals and sharing of other ''domestic'' activities, one participant in the day program noting:

> The day program has added structure to my day . . . it stopped me doing certain things . . . we are all just one great big family here, people helping each other . . . I like the fact that the program offers you an education, a free education, as well as giving you an affordable meal every day because a lot of people do not have funds to buy food, and they do not have money to go to school with.

It is worth noting that some participants thought that the ''family'' atmosphere could be improved by new measures. Many women were mothers of small children, and they suggested that some form of on-site child-care would allow for fuller and more rewarding participation in community life. Others argued for longer opening hours so that people could spend more time together. Though consumers were overwhelmingly positive about the ''family'' aspect of life in a recovery community, some people occasionally brought up what could be considered the negative aspects of traditional family-life, e.g., disruptive individuals or periodic ''gossip'' or ''backstabbing''.

Socialization and individual growth

The final common theme to emerge from the data was that of socialization and individual growth. It appeared that the ongoing constructive social interactions in the recovery community were prompting better coping strategies, a positive change in personal values and an increasingly optimistic view of other people, the future and life in general. This may all derive from the safety, trust and sense of kinship explored previously in the results. Participants reported that individual growth arose from informal contact and sharing with other consumers and staff, as well as through formal programs within the recovery community. One woman noted how positive social interaction offered in the community gave her a renewed approach to problem-solving and more confidence in handling difficult situations:

> I can piggy back [here], if I wasn't coming to this place, I would be so bent over, I would be so stressed out, since I have been coming to this place it has lifted my spirits, and when I have situations I need to talk about, I come in here and just throw it all out here, and people give me advice, and solutions, and different ways to handle situations.

This formation of meaningful inter-personal relationships was not based on exploitation, like many previous relationships ''on the street''. For many participants, this was the first time in a long while that they were forming positive and healthy intimate relationships with others. These could be transferable to encounters and situations beyond the recovery community. One woman stated, to echoes around the focus group that:

> This has taught me to be more assertive, more responsible, it has taught me to be more independent, taught me how to set boundaries in my life, taught me how to say no, and mean it, without feeling guilty.

Many consumers stated that the encouragement of responsibility and healthy independence was an important factor in their recovery, assisting transformation away from a lifestyle that was often dependent on illicit drugs or dysfunctional relationships. Consumers were so enthused at these developments that they thought they should be shared outside the community, one consumer noting, to agreement from others, that:

> I would like to see the women involved in this community go outside the community to take it out to the younger generation, teenage girls . . . I want them to hear my story also, people who have mental illness and people who have trauma recovery, we do have a voice . . . we could be like guest speakers and stuff, at functions and stuff.

Consumers certainly felt that the three factors outlined above were leading to hastened recovery from the negative impact of mental illness and other complicating difficulties.

Discussion

Participants lauded the recovery communities, stating that they were significant factors assisting recovery. From a systematic analysis of qualitative data, we identified three critical components of the communities that consumers value the most as assisting in recovery. The recovery community as a place of safety appears to be the foundation upon which ''familial feeling'' and individual growth and socialization is built. Safety appeared to emerge as the predominant factor due to two factors. Firstly, most consumers lived in deprived inner-city urban neighborhoods characterized by high levels of violence, personal danger and drug availability. Second, many consumers had themselves been on the receiving end of violence and abuse, as well as involved in substance abuse or other dangerous activities. The recovery community acted as a safe haven from these activities, helping to bracket out potentially negative exposures ''on the streets''. Within the shelter of this safety, familial relations developed with staff and peers which appeared to contribute to socialization and growth. These factors may especially impact on an SMI population, as many are alienated and estranged from their own family and experience fractured social relations and difficulty in the formation of friendships in the wider world (Beal et al., 2005). Indeed participants seemed to frame their recovery in these wider social terms: they were recovering not only from a mental illness (a biological disease), but also from baseline troubles of a social and cultural nature.

The intentional recovery community thus appeared to positively diminish the loneliness and despair so often identified as concomitant with SMI (Borge et al., 1999; Estroff, 1983). Many consumers placed a high value on the fellowship and instrumental support that was freely shared in all the recovery communities. The recovery community appears to go some way in compensating for the absence of biological families in consumers' lives. The safe space also appears to play an important role in re-building meaningful interpersonal

relationships (socialization), as many consumers noted that previous relationships were often dysfunctional, involving considerable exploitation or abuse. In contrast, relationships in the recovery community were more ''family-like''. Thus the community appeared to provide a facilitative environment for the development of social skills, social functioning and social support- all factors known to positively impact on mental health (Brugha, 1995; Cohen & Wills, 1985; Kawachi & Berkman, 2001; Liberman & Silbert, 2005). This gave the participants self-identified strength and hope in the present and for the future. Furthermore, the recovery community appeared to act as a base from which consumers could connect with others as well as ''venture forth'' into the world- two factors recently identified as imperative in the rehabilitation of people with SMI (Beal et al., 2005). Importantly, the communities were places to which people could return for positive reinforcement and sustenance from peers and staff alike after forays into the ''real world''.

Others have noted that this process of incremental improvements in socialization and individual growth can improve everyday functioning and coping, which can lead to positive real world outcomes, such as independent living and gainful employment (Allen & Haslam-Hopwood, 2005; Mead & Copeland, 2000; Mueser et al., 2005). Consumers definitely felt that the recovery communities were helping in the development of social skills allowing them to function better in everyday society. Again, this finding should be related back to the life histories of individual consumers. Many had been consistently involved in dysfunctional relationships and found themselves in dead-end situations. Thus, they had not followed common patterns of socialization, education or employment, in either formal or informal settings. The recovery community was making some positive recompense for this absence.

Some recent research has focused on the role self-authored, voluntary communities can play in mitigating the affects of SMI (e.g., Beal et al., 2005; Boydell et al., 2002). In this paper, we explored how far intentional communities can address social and cognitive deficits consequent upon SMI. We suggest that these types of modest initiatives can act as psychosocial shelters through which social skills can be re-learnt and meaningful bonds developed with others. This appears to positively affect recovery amongst consumers. It is hoped that these findings can provide useful guidance to mental health service providers in a similar inner-city milieu attempting to facilitate recovery and community integration amongst a similar SMI population.

Though our findings are consistent with existing literature, we recognize that this is a small-scale qualitative evaluation in a single setting. We thus present the results of our evaluation to the outside world not as generalizable conclusions, but as a grounded heuristic device that can be explored in further study. It may be that size of the recovery community and participant homogeneity may be critical variables that allow for meaningful development along the three identified indices. The small nature of our recovery communities may allow for increased feelings of safety and intimacy, and homogeneity in terms of other participants (e.g., all women, all adolescents) may increase feelings of fellowship and safety. Further work needs to address the optimal size of a recovery community as well as optimal forms and levels of homogeneity.

References

Allen, J. G., & Haslam-Hopwood, G. T. G. (2005). The value of social contacts. *Psychiatry*, *68*, 214–219.

Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*, 11–23.

Barnes, M., & Berke, J. (1973). *Mary Barnes: Two accounts of a journey through madness.* Harmondsworth, UK: Penguin.

Beal, G., Veldhorst, G., & McGrath, J.-L. et al. (2005). Constituting community: Creating a place for oneself. *Psychiatry*, *68*, 199–211.

Borge, L., Martinsen, E. W., Ruud, T. et al. (1999). Quality of life, loneliness, and social contact among long-term psychiatric patients. *Psychiatric Services*, *50*, 81–84.

Boydell, K., Gladstone, B. M., & Crawford, E. S. (2002). The dialectic of friendship for people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, *26*, 123–131.

Brugha, T. S. (1995). *Social support and psychiatric disorder.* Cambridge, UK: Cambridge University Press.

Cohen, S., & Wills, T. A. (1985). Stress, social support and the buffering hypothesis. *Psychological Bulletin*, *98*, 310–357.

Daloz, L. P., Keen, C. H., Keen, J. P., & Parks, S. D. (1996). *Common fire: leading lives of commitment in a complex world.* Boston, MA: Beacon Press.

Davidson, L. (2005). More fundamentally human than otherwise. *Psychiatry*, *68*, 243–249.

Deegan, P. (1988). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, *11*, 11–19.

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, *19*, 91–97.

Deegan, P. (1997). Recovery and empowerment for people with psychiatric disabilities. *Social Work and Health Care*, *25*, 11–24.

Estroff, S. (1983). How social is psychosocial rehabilitation? *Psychosocial Rehabilitation*, *7*, 6–19.

Fairweather, G. W., Sanders, D. H., Maynard, H. et al. (1969). *Community life for the mentally ill.* Chicago: Aldine.

Fountain House (1999). The wellspring of the clubhouse model for social and vocational adjustment of persons with serious mental illness. *Psychiatric Services*, *50*, 1473–1476.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New York: Aldine.

Harris, M., & Fallot, R. (2005). Principles for defining a recovery community. Unpublished manuscript.

Harris, M., Fallot, R. D., & Berley, R. W. (2005). Qualitative interviews with female abuse survivors on substance abuse relapse and relapse prevention. *Psychiatric Services*, *56*, 1292–1296.

Hinshelwood, R., & Manning, N. (1979). *Therapeutic communities.* London: RKP.

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health*, *76*, 458–467.

Krueger, R. A. (1994). *Focus groups, a practical guide for applied research.* Thousand Oaks, CA: Sage.

Liberman, R. P., & Silbert, K. (2005). Community re-entry: Development of life skills. *Psychiatry*, *68*, 220–229.

Lofland, J., & Lofland, L. H. (1995). *Analysing social settings: A guide to qualitative observation and analysis.* Belmont, CA: Wadsworth.

Madriz, E. (2000). Focus groups in feminist research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 835–850). Thousand Oaks, CA: Sage.

Mancini, M. A., Hardiman, E. R., & Lawson, H. A. (2005). Making sense of it all: Consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatric Rehabilitation Journal*, *29*, 48–55.

Mead, S., & Copeland, M. E. (2000) What recovery means to us: Consumers' perspectives. *Community Mental Health Journal*, *36*, 315–328.

Mueser, K. T., Aalto, S., Becker, D. R. et al. (2005). The effectiveness of skills training in improving outcomes in supported employment. *Psychiatric Services*, *56*, 1254–1260.

Munich, R. L., & Lang, E. (1993). The boundaries of psychiatric rehabilitation. *Hospital and Community Psychiatry*, *44*, 661–665.

New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America.* Final Report. DHHS pub no SMA-03-3832. Rockville, MD: Department of Health and Human Services.

Silver, A. L. (1997). Chestnut Lodge, then and now. *Contemporary Psychoanalysis*, *33*, 227–249.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research.* Newbury Park, CA: Sage.

Surgeon-General (1999). *Mental health.* A report of the Surgeon-General. Rockville, MD: Center for Mental Health Services, National Institute of Mental Health.

Wallerstein, R. S. (1986). *Forty-two lives in treatment.* New York: Guilford.

Whitley, R., & Crawford, M. (2005). Qualitative research in psychiatry. *Canadian Journal of Psychiatry*, *50*, 108–114.

Whitley, R., & McKenzie, K. (2005). Social capital and psychiatry: Review of the literature. *Harvard Review of Psychiatry*, *13*, 71–84.